Application Checklist for Speech-Language Pathology
Certificate of Clinical Competence
(US Graduates)

1. **Application**

2. **License Fees**
   - Check or Money Order to Board for $60.

3. **Verification of Certification Letter from ASHA**

4. **Fingerprints**

   - If a California resident, must do Livescan; send a copy of your form to the Board. Fees paid directly to Livescan Operator.

   - If out-of-state, send four cards and a check or money order to Board for $49 to cover DOJ and FBI.

NOTE:
If you completed your CFY/RPE in California or outside of the United States, you must complete our RPE Verification form. You must provide proof that your supervisor was certified at the time of your experience.

If your certification was issued based on the Quadrilateral Mutual Recognition Agreement you do not qualify for this option.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
2005 EVERGREEN STREET, SUITE 2100, SACRAMENTO, CA 95815
PHONE (916) 263-2666 FAX (916) 263-2668
WWW.SPEECHANDHEARING.CA.GOV

APPLICATION FOR LICENSURE

CERTIFICATE OF CLINICAL COMPETENCE

OFFICE USE ONLY	
RECEIPT #:	
ATS #:	
AMOUNT PAID:	
DATE CASHIERED:	

IMPORTANT: TO QUALIFY FOR LICENSURE WITH EQUIVALENT QUALIFICATIONS YOU HOLD A CURRENT CERTIFICATE OF CLINICAL COMPETENCE ISSUED BY THE AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION. IF YOUR CERTIFICATION WAS ISSUED UNDER THE GUIDELINES OF THE QUADRILATERAL MUTUAL RECOGNITION AGREEMENT YOU DO NOT QUALIFY FOR THIS PACKET.

NOTICE: EFFECTIVE JULY 1, 2012, THE STATE BOARD OF EQUALIZATION, AND THE FRANCHISE TAX BOARD MAY SHARE TAXPAYER INFORMATION WITH THE BOARD. YOU ARE OBLIGATED TO PAY YOUR STATE TAX OBLIGATION AND YOUR LICENSE MAY BE SUSPENDED IF THE STATE TAX OBLIGATION IS NOT PAID.

INSTRUCTIONS: ANY CORRECTIONS TO THIS FORM MUST BE STRICKEN AND INITIALED. **DO NOT USE WHITE OUT OR CORRECTION TAPE ON THIS APPLICATION!** IF ANY SECTIONS ARE NOT COMPLETE, THIS APPLICATION WILL BE RETURNED. YOU MUST INCLUDE A CHECK OR MONEY ORDER FOR $60.00 ALONG WITH THISAPPLICATION.

SPEECH-LANGUAGE PATHOLOGY ☐ **AUDIOLOGY** ☐ **DISPENSING AUDIOLOGIST** ☐

PLEASE TYPE OR PRINT NEATLY

1. FULL NAME: LAST FIRST MIDDLE

2. OTHER NAMES YOU HAVE USED (INCLUDING MAIDEN):

3. *ADDRESS: STREET

CITY, STATE, ZIP CODE

4. RESIDENCE TELEPHONE: BUSINESS TELEPHONE:

5. SOCIAL SECURITY NUMBER: DATE OF BIRTH: (MM/DD/YYYY)

EMAIL ADDRESS:

6. EDUCATION:

MASTER'S DEGREE ☐ MASTER'S DEGREE EQUIVLENCY ☐ AU.D. DEGREE OR AU.D. STUDENT ☐

7. EMPLOYER:

STREET ADDRESS: CITY, STATE, ZIP CODE:

8. GRADUATE AND UNDERGRADUATE PROGRAMS.

INSTITUTION NAME	CITY/STATE	MAJOR FIELD OF STUDY	DEGREE RECEIVED AND DATE

*YOUR ADDRESS IS PUBLIC INFORMATION AND WILL BE PLACED ON THE INTERNET.

9. HAVE YOU TAKEN THE EDUCATIONAL TESTING SERVICE/NATIONAL TEACHER EXAMINATION (NTE) (THE PRAXIS SERIES) IN SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY?

YES _____ NO _____ IF YES, DATE _____/_____ (MONTH / YEAR) YOUR SCORE:_____ (MINIMUM SCORE OF 600 REQUIRED)

10. IN WHAT STATE WAS YOUR SUPERVISED PROFESSIONAL EXPERIENCE, CFY, OR 4TH YEAR EXTERNSHIP COMPLETED?

_____

IF IT WAS COMPLETED IN CALIFORNIA YOU WILL BE REQUIRED TO SUBMIT A REQUIRED PROFESSIONAL EXPERIENCE VERIFICATION FORM.

11. WAS YOUR ASHA CERTIFICATION ISSUED UNDER THE GUIDELINES OF THE QUADRILATERAL MUTUAL RECOGNITION AGREEMENT?

YES _____ NO _____

IF YES, THIS IS THE WRONG APPLICATION PACKET, YOU MUST USE THE REQUIRED PROFESSIONAL EXPEREINCE PACKET (FOREIGN GRADUATES).

12. DO YOU HAVE ANY PENDING OR HAVE YOU EVER HAD ANY DISCIPLINARY ACTION TAKEN OR CHARGES FILED AGAINST A SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, HEARING AID DISPENSING, OR OTHER HEALING ARTS LICENSE? INCLUDE ANY DISCIPLINARY ACTIONS TAKEN BY ANY STATE OR OTHER U.S. FEDERAL GOVERNMENT ENTITY.

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

DISCIPLINARY ACTION INCLUDES, BUT IS NOT LIMITED TO, SUSPENSION, REVOCATION, PROBATION, CONFIDENTIAL DISCIPLINE, CONSENT ORDER, LETTER OF REPRIMAND OR WARNING, OR ANY OTHER RESTRICTIONS OF ACTION TAKEN AGAINST A SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY LICENSE.

13. ARE THERE ANY PENDING INVESTIGATIONS BY ANY STATE OR FEDERAL AGENCIES AGAINST YOU?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

14. HAVE YOU EVER BEEN THE SUBJECT OF ANY DISCIPLINARY ACTION REGARDING ANY SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, HEARING AID DISPENSING, OR OTHER HEALING ARTS LICENSE, WHICH YOU NOW HOLD OR HAVE PREVIOUSLY HELD?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

15. HAVE YOU EVER BEEN DENIED A LICENSE TO PRACTICE SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, HEARING AID DISPENSING, OR OTHER HEALING ARTS, IN ANY STATE?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

16. HAVE YOU EVER VOLUNTARILY SURRENDERED A LICENSE TO PRACTICE SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, HEARING AID DISPENSING OR OTHER HEALING ARTS IN ANOTHER STATE?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

17. HAVE YOU EVER BEEN CONVICTED OF, OR PLED NOLO CONTENDERE TO ANY OFFENSE, MISDEMEANOR OR FELONY OF ANY STATE, THE UNITED STATES OR A FOREIGN COUNTRY? (EXCEPT VIOLATIONS OF TRAFFIC LAWS RESULTING IN FINES OF $300 OR LESS)

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND/OR DISMISSED UNDER PENAL CODE SECTION 1203.4 OR UNDER ANY OTHER PROVISION OF THE LAW.

18. AUDIOLOGY APPLICANTS ONLY, DO YOU WISH TO DISPENSE HEARING AIDS?

YES _____ NO _____ IF YES, COMPLETE THE HEARING AID DISPENSER WRITTEN LICENSE EXAMINATION APPLICATION

YOU MUST REPORT TO THE BOARD THE RESULT OF ANY ACTIONS WHICH HAVE BEEN FILED OR WERE PENDING AGAINST ANY SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY LICENSE YOU HOLD AT THE FILING OF THIS APPLICATION. FAILURE TO REPORT THIS INFORMATION MAY RESULT IN THE DENIAL OF YOUR APPLICATION OR SUBJECT YOUR LICENSE TO DISCIPLINE PURSUANT TO SECTION 480 (C) OF THE BUSINESS AND PROFESSIONS CODE.

ATTACH 2" X 2" OR 3" X 3"
PASSPORT QUALITY
PHOTOGRAPH HERE. YOU MUST PRINT YOUR FULL NAME ON THE BACK OF THE PHOTOGRAPH. THE PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE 60 DAYS OF THE FILING DATE OF THIS APPLICATION.

PHOTOS PRINTED ON WHITE BOND PAPER ARE **NOT** ACCEPTABLE.

I HEREBY CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT ALL STATEMENTS MADE HEREIN ARE TRUE IN EVERY RESPECT, AND THAT MISSTATEMENTS OR OMISSIONS OF MATERIAL FACTS MAY BE CAUSE FOR DENIAL OF THIS APPLICATION, OR FOR SUSPENSION OR REVOCATION OF A LICENSE.

DATE: _____ SIGNATURE: _____
(SIGNATURE MUST BE IN BLUE INK)

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 (Code assigned by DOJ) Type of Application: (check one) ___ Employment X License, Certification, Permit ___ Volunteer

Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Aide

PLEASE CIRCLE ONE

Agency Address Set Contributing Agency:

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
Agency authorized to receive criminal history information

06187
Mail Code (five-digit code assigned by DOJ)

2005 Evergreen Street, Suite 2100
Street No. Street or PO Box

N/A
Contact Name (Mandatory for all school submissions)

Sacramento CA 95815
City State Zip Code

( )
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ___ Male ___ Female

Misc. No. **BIL -** Applicant Must Pay At Site
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: 7700 SLP/AU
OCA No. (Agency Identifying No.)

Level of Service DOJ X FBI X

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____
Name of Operator

Date _____

Transmitting Agency

ATI No.

Amount Collected/Billed

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Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

BCII 8016 (Rev10/98) **ORIGINAL-Live Scan Operator; SECOND COPY-Requesting Agency; THIRD COPY-Applicant**